THE COMMONWEALTH OF MASSACHUSETTS

Department of Industrial Accidents

1 Congress Street, Suite 100
Boston, Massachusetts 02114-2017

WHEN TO FILL OUT THE FORM 101
EMPLOYER FIRST REPORT OF INJURY/FATALITY

This form should be filled out when an employee is injured, or alleges an injury, and is unable to **earn full wages for five or more calendar days** (Mondays through Sundays). It is the responsibility of the employer to report an alleged injury, whether or not the employer agrees with the employee's claim or not.

This form must be filed within ***seven (7) business days*** (not counting Sundays and legal holidays), from the fifth day of disability.

The form with the original signature should be sent to the DIA. You should make **three (3)** additional copies:

- One for the employee.
- One for your insurance company.
- One for your own records.

The Form 101 should be filled out as fully as possible. Below is additional guidance for filling out some selected boxes on the form. All other relevant boxes should also be filled out.

Box 1 -- Please print or type the employee's last name, first name, and middle initial, as you know it.

Box 5 -- Please print or type the employee's address.

Box 5a -- Please print or type the employee's native language using the NATIVE LANGAUGE CODES on the back of the form.

Box 8 -- Please indicate the date the employee was hired.

Box 9 -- Please print the employee's date of birth.

Box 10 -- Please print the gross amount the employee earns each week.

Box 11 -- Please print or type the full name of your business.

Box 13 -- Please print your company's address. This is the address any official notices will be sent to.

Box 15 -- Please print your industrial code. A directory of codes is on the back of the form. If you cannot find an appropriate code number, use 99.

Box 16 -- Please print the name of your workers' compensation insurance carrier (**not** the agent who sold the policy).

Box 18 -- If your company is certified by the DIA as a self-insurer, check yes. If it is not, check no.

Box 20 -- Please type the date the employee suffered the injury, or alleged injury. If you are not sure, put the last full day the employee worked.

Box 20a -- Please print or type the claim number/case file number your workers' compensation carrier has assigned to this claim.

Box 23 -- Please type in the **first calendar** day the employee was disabled (fully or partially) due to their injury.

Box 24 -- Please type in the **fifth calendar** day the employee was disabled (fully or partially) due to their injury.

Box 29 -- Please indicate the date that the injury was reported to you.

Box 31 -- Please indicate the injury code(s) and body part code(s), from the lists on the back of the form. If you cannot find an appropriate code, use 999.

Box 32 -- Please list the names of any witnesses to the injury.

Box 33 -- Indicate whether or not the employee has returned to work.

Box 34 -- Please print the date that the employee returned to work, if applicable.

Box 37 -- Please print the name of the person preparing the form (this **cannot** be the injured worker).

Box 39 -- Please sign here (the **original** signature must be on the form sent to the DIA).

Box 40 -- The date the form is prepared should be entered in this space.

Box 40a -- Please print or type the e-mail address of the person preparing this form